VERMONT HEALTH CONNECT
Find the plan that's right for you.

Small Business
Health coverage application for EMPLOYEES

APPENDIX B: MVP

EMPLOYER NAME (please print): _____

PRIMARY WORKSITE ADDRESS: _____

EMPLOYEE NAME (please print): _____ SSN: _____

Employees who are offered health insurance from their employer may be eligible for financial help through Vermont Health Connect only if the health insurance offered by their employer is unaffordable or inadequate. Once an employee enrolls in the employer's health insurance he or she is no longer eligible for financial help through Vermont Health Connect, even if the employer insurance is unaffordable or inadequate. I understand that by enrolling in my employer's insurance, I will NOT be eligible for financial help from Vermont Health Connect even if my employer's insurance is unaffordable or inadequate. I have reviewed the Summary of Benefits and Coverage for my plan and understand its terms and conditions.

*If you would like to see if you may be eligible for financial help through Vermont Health Connect, visit the Affordability Calculator at http://info.healthconnect.vermont.gov/ESICalculator or fill out the "Application for Health Coverage and Help Paying Costs."

Privacy

We will keep your information private as required by law. Your answers on this form will only be used to see if you qualify for health coverage in Vermont Health Connect, and to help you enroll.

I have consent from all people I will list on the application to include their personally identifiable information, like dates of birth, Social Security numbers, addresses, and phone numbers. ◯ Yes ◯ No

Contact Information

Please tell us the best way to get in touch with the employee listed above:

◯ Home Phone: _____ ◯ Work Phone: _____

◯ Cell Phone: _____ ◯ Email Address: _____

Household Coverage Information

If premiums your family would pay for this employer-sponsored coverage are too expensive, you might be eligible for an exemption from the individual shared responsibility payment , or your family might be eligible for tax credits to help pay for insurance. If what you, the employee, would pay in premiums for single coverage in the lowest-cost plan offered by your employer is more than 8% of your family's monthly income, you may be exempt from the individual shared responsibility payment because the health insurance would be considered unaffordable. If the lowest-cost single premium is more than 9.5% of your family's monthly income, you may qualify for financial help to pay for insurance.

By choosing "Yes" I affirm that I understand what is written above. ◯ Yes ◯ No

Employee Plan Selection

Please choose the plan that you wish to enroll in by checking the box to the left.

	Medical Plan	Tier	Total Monthly Premium	Employer Contribution	Employee Responsibility
◯	MVP VT Vitality Platinum Standard	Single	$ 594.30	$	$
		Couple	$ 1,188.60	$	$
		Parent and Child(ren)	$ 1,147.00	$	$
		Family	$ 1,669.98	$	$
◯	MVP VT Vitality Gold Standard	Single	$ 513.83	$	$
		Couple	$ 1,027.66	$	$
		Parent and Child(ren)	$ 991.69	$	$
		Family	$ 1,443.86	$	$
◯	MVP VT Vitality Silver Standard	Single	$ 427.51	$	$
		Couple	$ 855.02	$	$
		Parent and Child(ren)	$ 825.09	$	$
		Family	$ 1,201.30	$	$
◯	MVP VT Vitality Bronze Standard *	Single	$ 336.13	$	$
		Couple	$ 672.26	$	$
		Parent and Child(ren)	$ 648.73	$	$
		Family	$ 944.53	$	$
◯	MVP VT Vitality Silver *HDHP* *Can be paired with HSA*	Single	$ 428.58	$	$
		Couple	$ 857.16	$	$
		Parent and Child(ren)	$ 827.16	$	$
		Family	$ 1,204.31	$	$
◯	MVP VT Vitality Bronze *HDHP* * *Can be paired with HSA*	Single	$ 366.22	$	$
		Couple	$ 732.44	$	$
		Parent and Child(ren)	$ 706.80	$	$
		Family	$ 1,029.08	$	$
◯	MVP Vitality Plus Gold HMO 500 Non-Standard	Single	$ 521.59	$	$
		Couple	$ 1,043.18	$	$
		Parent and Child(ren)	$ 1,006.67	$	$
		Family	$ 1,465.67	$	$
◯	MVP Vitality Plus Silver HMO 1700 Non-Standard	Single	$ 419.17	$	$
		Couple	$ 838.34	$	$
		Parent and Child(ren)	$ 809.00	$	$
		Family	$ 1,177.87	$	$
◯	MVP Vitality Plus Bronze HMO 3000 Non-Standard *	Single	$ 341.95	$	$
		Couple	$ 683.90	$	$
		Parent and Child(ren)	$ 659.96	$	$
		Family	$ 960.88	$	$
◯	I decline medical coverage.				

**Please note*: *The Bronze plans have the potential for significant out-of-pocket costs in addition to the premium.*

MEDICAL

Please tell us about the members of the family that will be insured on the medical plan:

Relationship to Employee	Name	Social Security Number	Date of Birth	Marital Status*	Other Insurance**?
Self					◯ Yes ◯ No
If this person has other medical insurance, please tell us the source:		◯ Individual private health insurance ◯ Insurance from another job ◯ Insurance through another person's job ◯ VA health care programs		◯ Medicare ◯ Medicaid ◯ TRICARE ◯ Indian Health Services	
Is this person the household member who is filling out this application?					◯ Yes ◯ No
Does this person have a physical or mental health condition that limits his ability to work, attend school, or take care of their daily needs?					◯ Yes ◯ No
Is this person an American Indian or Alaska Native?					◯ Yes ◯ No
Is this person a Member of a federally recognized tribe? If yes, what is the state of the federally recognized tribe? _____ What is the tribe name? _____					◯ Yes ◯ No

Relationship to Employee	Name	Social Security Number	Date of Birth	Marital Status*	Other Insurance**?
Spouse					◯ **Yes** ◯ **No**
If this person has other medical insurance, please tell us the source:		◯ Individual private health insurance ◯ Insurance from another job ◯ Insurance through another person's job ◯ VA health care programs		◯ Medicare ◯ Medicaid ◯ TRICARE ◯ Indian Health Services	
Does this person live at the same address as the Employee?			◯ Yes ◯ No		
If not, please tell us the correct address:					
Is this person the household member who is filling out this application?					◯ Yes ◯ No
Does this person have a physical or mental health condition that limits his ability to work, attend school, or take care of their daily needs?					◯ Yes ◯ No
Is this person an American Indian or Alaska Native?					◯ Yes ◯ No
Is this person a Member of a federally recognized tribe? If yes, what is the state of the federally recognized tribe? _____ What is the tribe name? _____					◯ Yes ◯ No

*Marital status: M-Married, NM-Never Married, W-Widowed, LS-Legally Separated, SEP-Separated, D-Divorced, DP-Domestic Partner, CU – Civil Union **Will this employee (and family members if applicable), have other sources of health coverage once this employer's Vermont Health Connect plan is effective? If so, you will need to tell us the source below.

Relationship to Employee	Name	Social Security Number	Date of Birth	Marital Status*	Other Insurance**?
Dependent 1					◯ **Yes** ◯ **No**
If this person has other medical insurance, please tell us the source:		◯ Individual private health insurance ◯ Insurance from another job ◯ Insurance through another person's job ◯ VA health care programs		◯ Medicare ◯ Medicaid ◯ TRICARE ◯ Indian Health Services	
Does this person live at the same address as the Employee?		◯ Yes ◯ No			
If not, please tell us the correct address:					
Is this person the household member who is filling out this application?					◯ Yes ◯ No
Does this person have a physical or mental health condition that limits his ability to work, attend school, or take care of their daily needs?					◯ Yes ◯ No
Is this person an American Indian or Alaska Native?					◯ Yes ◯ No
Is this person a Member of a federally recognized tribe? If yes, what is the state of the federally recognized tribe? _____ What is the tribe name? _____					◯ Yes ◯ No

Relationship to Employee	Name	Social Security Number	Date of Birth	Marital Status*	Other Insurance**?
Dependent 2					◯ **Yes** ◯ **No**
If this person has other medical insurance, please tell us the source:		◯ Individual private health insurance ◯ Insurance from another job ◯ Insurance through another person's job ◯ VA health care programs		◯ Medicare ◯ Medicaid ◯ TRICARE ◯ Indian Health Services	
Does this person live at the same address as the Employee?		◯ Yes ◯ No			
If not, please tell us the correct address:					
Is this person the household member who is filling out this application?					◯ Yes ◯ No
Does this person have a physical or mental health condition that limits his ability to work, attend school, or take care of their daily needs?					◯ Yes ◯ No
Is this person an American Indian or Alaska Native?					◯ Yes ◯ No
Is this person a Member of a federally recognized tribe? If yes, what is the state of the federally recognized tribe? _____ What is the tribe name? _____					◯ Yes ◯ No

*__Marital status__: M-Married, NM-Never Married, W-Widowed, LS-Legally Separated, SEP-Separated, D-Divorced, DP-Domestic Partner, CU – Civil Union **Will this employee (and family members if applicable), have other sources of health coverage once this employer's Vermont Health Connect plan is effective? If so, you will need to tell us the source below.

Relationship to Employee	Name	Social Security Number	Date of Birth	Marital Status*	Other Insurance**?
Dependent 3					◯ **Yes** ◯ **No**
If this person has other medical insurance, please tell us the source:		◯ Individual private health insurance ◯ Insurance from another job ◯ Insurance through another person's job ◯ VA health care programs		◯ Medicare ◯ Medicaid ◯ TRICARE ◯ Indian Health Services	
Does this person live at the same address as the Employee?			◯ Yes ◯ No		
If not, please tell us the correct address:					
Is this person the household member who is filling out this application?					◯ Yes ◯ No
Does this person have a physical or mental health condition that limits his ability to work, attend school, or take care of their daily needs?					◯ Yes ◯ No
Is this person an American Indian or Alaska Native?					◯ Yes ◯ No
Is this person a Member of a federally recognized tribe? If yes, what is the state of the federally recognized tribe? _____ What is the tribe name? _____					◯ Yes ◯ No

Relationship to Employee	Name	Social Security Number	Date of Birth	Marital Status*	Other Insurance**?
Dependent 4					◯ **Yes** ◯ **No**
If this person has other medical insurance, please tell us the source:		◯ Individual private health insurance ◯ Insurance from another job ◯ Insurance through another person's job ◯ VA health care programs		◯ Medicare ◯ Medicaid ◯ TRICARE ◯ Indian Health Services	
Does this person live at the same address as the Employee?			◯ Yes ◯ No		
If not, please tell us the correct address:					
Is this person the household member who is filling out this application?					◯ Yes ◯ No
Is this person a Member of a federally recognized tribe? If yes, what is the state of the federally recognized tribe? _____ What is the tribe name? _____					◯ Yes ◯ No

*__Marital status__: M-Married, NM-Never Married, W-Widowed, LS-Legally Separated, SEP-Separated, D-Divorced, DP-Domestic Partner, CU – Civil Union **Will this employee (and family members if applicable), have other sources of health coverage once this employer's Vermont Health Connect plan is effective? If so, you will need to tell us the source below.

DENTAL

Please complete this section only if your employer is offering dental coverage.

Please note:

- The dental plan tier definitions differ from the medical plan tiers.
- Pediatric Dental (up to the end of the calendar year in which the child turns 21) is embedded in the above medical plans.
- There is a 6-month waiting period for Major Dental Care – Adults only.

If your children are covered on the medical plan you've chosen above, DO NOT include these children in choosing a dental plan below.

	Stand Alone Dental Plan	Tier	Total Monthly Premium	Employer Contribution	Employee Responsibility
◯	Adult Plan	Individual	$ 46.93	$	$
		Two-Person	$ 89.62	$	$
◯	Adult Plan with High Pediatric Option *$50 Adult Deductible (per person)* *$50 Pediatric Ded. (per person)*	Single Head of Household with one or more children	$ 122.12	$	$
		Family	$ 165.34	$	$
		Rates per child*	$ 38.64	$	$
◯	Adult Plan with Low Pediatric Option *$50 Adult Deductible (per person)* *$625 Pediatric Ded. (per person)*	Single Head of Household with one or more children	$ 110.74	$	$
		Family	$ 160.34	$	$
		Rates per Child*	$ 32.79	$	$
◯	I decline dental coverage.				

Notes:

- Children eligible for Pediatric Only through the last day of the benefit year they turn 21
- Dependent children include: biological children, adopted children, step-children, and children for whom subscriber is legal guardian

Please tell us about the members of the family that will be insured on the dental plan.

If your children are covered on the medical plan you've chosen above, DO NOT include these children in the list below.

Relationship to Employee	Name	SSN	DOB
Self			
Spouse			
Dependent 1			
Dependent 2			
Dependent 3			
Dependent 4			

Other

Did the employee's employer direct them to enroll in employer-sponsored insurance through the Exchange? ◯ Yes ◯ No

Please tell us how you heard about Vermont Health Connect.

◯ Employer	◯ Friends/Family	◯ Mail
◯ News	◯ Internet	◯ Other

Please sign below.

Print name: _____

Signature: _____ Date: _____

Mail completed and signed form to:

Vermont Health Connect, 103 South Main Street, Waterbury, VT 05671-8100

For certified application counselors, navigators and brokers only. Complete this section if you are a certified application counselor, navigator or broker filling out this application for somebody else.

PLEASE PRINT

Application start date: _____

First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____

Organization name: _____

ID number (if applicable): _____

Brokers will need to have a Broker Designation Agreement signed and kept by both the client and the broker.